STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to prevent an unintentional fire related to 1 of 1 resident (R1) who set fire to oxygen when she was smoking in her room. R1 remained in possession of a lighter and cigarettes after the fire, placing all 63 residents at likelihood of serious harm or death. The Immediate Jeopardy began on 1/29/26 when the facility failed to ensure R1's smoking materials were secured per the care plan, resulting in R1 lighting a cigarette in her room, with oxygen in use, and igniting an unintended fire. The facility did not implement appropriate supervision, monitoring, and interventions to prevent recurrence, and R1 continued to possess a lighter and cigarettes without staff knowledge resulting in the likelihood of serious harm or death for R1 and other residents at the facility. The administrator and director of nursing (DON) were notified of the IJ on 2/2/26 at 3:12 p.m. The IJ was removed on 2/2/26 when the facility implemented immediate corrective action to prevent reoccurrence, but noncompliance remained at a lower scope and severity of D with no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include R1's face sheet dated 1/30/26 indicated she had diagnoses of type II diabetes, pulmonary fibrosis (thickening of lung tissue), chronic obstructive pulmonary disease (damage to the lungs), depression, nicotine dependence and dementia. R1's Medicare 5-day Minimum Data Set (MDS) dated [DATE] indicated R1 was moderately cognitively impaired and independent in activities of daily living. During the assessment period R1 had no behaviors and no rejection/refusals were noted. R1 required continuous oxygen and had no limitations in her range of motion. R1's Smoking Evaluation form dated 12/19/25 indicated R1 was safe to smoke independently. R1 had no cognitive loss even though R1 had a diagnosis of dementia and the MDS identified R1 had moderate cognitive impairment. R1 had no visual deficits or dexterity problems. R1 smoked 2-5 times per day. R1 could light her own cigarette and had been deemed safe to store/handle her own cigarette and lighter. The assessment did not address if R1 demonstrated understanding of safety measures that addressed the removal of oxygen and/or placement of oxygen equipment prior to smoking. R1's smoking care plan initiated 12/23/25, identified a goal of resident will smoke safely and independently. Interventions as follows. -12/23/25 educated on potential dangers of oxygen and cigarette smoking. -12/23/25 independent with smoking per evaluation -12/23/25 smoking evaluation per facility policy and as needed. Although the care plan identified R1 was provided with education on the potential dangers of oxygen, there was no interventions that guided/directed placement of oxygen equipment prior and/or during smoking. R1's incident analysis form dated 12/24/25 identified R1 was found smoking in her room. The contributing factors identified were R1 being a new admission to the facility and she was independent with smoking according to her admission smoking form. R1 was re-educated and the care plan was updated to remove smoking materials and keep them at the nursing station. R1's smoking evaluation dated 12/24/25 indicated R1 did not have cognitive loss even though the MDS identified moderate cognitive impairment and R1 had a (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diagnosis of dementia, no visual deficits or dexterity problems. R1 smoked 5-10 times per day, could light her own cigarette and could not store her own smoking materials. R1's smoking materials were to be kept at the nursing station. R1 had been found smoking in her room. The smoking policy was reviewed with R1. R1's care plan was not revised until 12/29/25 (six days after R1 was found smoking in her room.) The care plan was updated with the intervention to store smoking materials at the nurse station. R1's Risk vs Benefits form dated 12/30/25 indicated the area of concern was R1 smoking in the room while on oxygen. The form did not identify the date or dates of when R1 was smoking in her room. The risks related to non-compliance was documented as smoking in a room while using oxygen is extremely dangerous because oxygen itself is not flammable but greatly accelerates combustion, causing fires to ignite faster, burn hotter, and spread explosively. Even a small spark from a cigarette, lighter or match can trigger a flash fire when oxygen has saturated clothing, bedding, hair or furniture. These fires can cause severe burns, permanent lung damage, and death within seconds, not only to the person on oxygen but also to others in the home. In addition, oxygen related fires are difficult to extinguish and can rapidly lead to structural damage. For these reasons, smoking should never occur in the same room when oxygen is in use. The form did not include any benefits associated with the risks that were identified. Furthermore, the form was not signed by R1, her guardian or any family members. In review of R1's record there was no indication of monitoring and evaluation of effectiveness of R1's care plan intervention that directed to store smoking materials at the nurse's station. R1's progress notes dated 1/29/26 at 8:39 a.m. indicated R1 was smoking in her room and caused a fire (indicating the 12/29/25 intervention was not followed that directed to keep smoking materials at the nurse's station). R1 denied smoking in her room and refused a respiratory assessment and skin check. R1 was removed from the room and responsible parties were notified. R1's Smoking Evaluation dated 1/29/26 indicated R1 did not have cognitive loss even though the MDS identified moderate cognitive impairment and R1 had a diagnosis of dementia. R1 had no visual deficits or dexterity problems. R1 smoked 5-10 times per day, could light her own cigarette and could not store her own smoking materials. The following summary was included, Per observation resident is independent lighting, smoking and extinguishing cigarettes, resident has been deemed unsafe to store smoking cigarettes independently, smoking materials are supposed to be kept at the nurse's station, daily checks to be done on room. Resident use oxygen Resident has been educated to remove and store oxygen prior to smoking. Resident has wanderguard on portable oxygen tank. Resident verbalized understanding R1's incident analysis form dated 1/29/26 identified R1's oxygen tank was on fire in her room. Staff heard R1's roommate yelling help and responded. Staff found a fire in R1's room on the oxygen tank. R1 was smoking but denied smoking. The fire was put out. R1 and the roommate were assessed; no injuries were found. R1 was moved to a different room and the roommate proceeded with a previously planned discharge. A search was completed; a pack of cigarettes was found and placed at the nurse's station. In the contributing factors section, the 12/23/25 (date conflicts with date of incident) smoking infraction was identified and R1 was re-educated at that time to the smoking policy, with the plan to start keeping smoking materials at the nurse's station. Interviews with two staff showed they had no concern with R1 after the first smoking incident. The night of 1/29/26, R1 was agitated because she thought she had an appointment in the morning. R1 may have been confused after hearing about her roommate's discharge and thought she needed to do something. Ongoing interventions included, -R1 was re-educated regarding risks of smoking with oxygen. -Nursing order to do daily room checks for smoking materials -Guardian and family contacted to give smoking materials to the nursing station during visits -ACP (Associated clinics of psychology) notified -Spanish and English sign placed in room to remind (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident to not smoke -15-minute checks implemented. R1's smoking care plan identified on 1/29/26 the following interventions were added: -1/29/26 daily - request permission from resident to complete room search. If allows then please search and remove and smoking materials found. -1/29/26 safety checks -1/29/26 signs posted in room in Spanish to remind about no smoking and that oxygen is flammable -1/29/26 visualize room every shift. Remove any smoking materials that are easily observed and bring to nursing station for safety -1/29/26 wanderguard to portable oxygen tank - check placement every shift and function daily In review of R1's record between 1/29/26 through 2/2/26 the record did not include a comprehensive assessment or analysis on how 15-minute checks were appropriate or sufficient for R1 to prevent R1 from smoking in the facility. Additionally, the care plan did not address and/or give instructions to staff when if R1 was non-compliant with keeping smoking material in her room and/or refuse to give smoking materials to staff in accordance with the care plan. In review of R1's clinical record, although cognitive screening was completed as part of the MDS (Brief Interview of Mental Status) that identified moderate cognitive impairment and R1's diagnosis of Dementia, there was no documented assessment evaluating R1's task-specific decisional capacity to safely engage in smoking while using oxygen. The record did not include an evaluation of R1's ability to understand, retain, and consistently apply smoking safety requirements, including judgment and executive functioning related to compliance with the facility's smoking policy even though R1 demonstrated non-compliance on 12/24/25 and 1/29/26 when R1's care plan for storage of smoking materials was not followed, did not follow the smoking risks document dated 12/29/25, and the facility analysis that indicated R1 may have been confused. During an observation and interview on 2/2/26 at 9:13 a.m., R1 was in her room and stated she did not trust staff with her smoking materials. R1 stated she refused to give staff her smoking materials when they asked her for them. R1 reached into her coat pocket and pulled out a box of cigarettes with a lighter. She had her nasal cannula on and connected to her oxygen tank running at 2 LPM (liters per minute). R1 denied causing a fire in her room on 1/29/26. During an interview on 2/2/26 at 9:31 a.m., nursing assistant (NA)-A indicated R1 would refuse to give her smoking materials to staff when staff requested her items after she returned from smoking outside. Staff had not had time yet to check today (2/2/26) if R1 had smoking materials in her possession, but she likely did. NA-A stated staff don't always have time to check residents when they come back to the floor after smoking to make sure they have given the smoking materials to the nursing station. NA-A had warned R1 a few times because he smelled it in her room and R1 would deny it (unable to give exact dates). NA-A would report smoking concerns to the nurse or nurse manager. NA-A was not sure what new interventions were in place after the fire besides the 15-minute checks. R1 would be able to smoke a cigarette in between the 15-minute checks. R1's record reviewed between 12/24/25 through 2/2/26 did not include accounts of R1 smoking in her room except on 12/24/25 and 1/29/25. During an interview on 2/2/26 at 10:30 a.m., licensed practical nurse (LPN)-A stated she was not aware of R1 smoking in her room and was unaware she had a lighter in her possession currently. R1 had been non-complaint with her smoking care plan and had a risk versus benefits form in place. LPN-A would notify nursing management if R1 refused to give up her smoking materials. LPN-A showed the drawer at the nursing station where smoking materials would be kept. The drawer did not contain any smoking materials; it was full of miscellaneous office supplies. LPN-A verified there was no log to keep track of smoking supplies, but the facility could put a log into place. Facility records/protocols did not identify a system to track resident smoking materials when stored at the nursing station. During an interview on 2/2/26 at 3:57 p.m., registered nurse (RN)-A stated R1 was non-compliant with smoking and had a mind of her own. RN-A had educated her about not smoking in her room prior to the fire. RN-A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	did not clarify if R1 was understanding of the education. Staff were not sure where or how R1 was obtaining smoking supplies but sometimes residents shared with each other. Placing 15-minute checks on R1 was decided by management and facility policies and not based on a comprehensive assessment. R1 would be able to smoke in her room or go outside in between the 15-minute checks but R1 had her own will and freedom. RN-A had not received reports of R1 smoking in her room from nursing assistants. R1 knew she was supposed to keep her smoking materials at the nursing desk so she would hide her materials. RN-A did not clarify what should be done when R1 refused to give up her smoking materials. RN-A responded to the fire during the night shift on 1/29/26 when she heard someone screaming for help and shouting fire. R1 had turned her oxygen off. R1 was right next to her oxygen tank. A nursing assistant helped remove R1 and the roommate. RN-A alerted the emergency system by pulling the fire alarm, calling 911 and paging code red. No residents or staff were injured. R1's record reviewed between 12/24/25 through 2/2/26 did not include accounts of R1 hiding smoking materials and refusals to give up her smoking materials. During an interview on 2/2/26 at 10:00 a.m., NA-B stated R1 often refused to give her lighter up to nursing staff. It was a shared responsibility between nursing assistants and nurses to obtain her smoking materials. NA-B would report it to the nurse manager when R1 refused to give up her smoking materials. NA-B could not specify what would happen once management was aware of R1 not giving up her smoking materials. NA-B had not been told much about what new interventions were in place following the fire. During an interview on 2/2/26 at 12:20 p.m., the director of nursing (DON) stated it was hard to take things from R1, family would bring her smoking materials without bringing it to the nursing station first. It was noticed that R1 had a lighter on her this morning (2/2/26), she refused to give it up and she was placed on one-to-one observation. R1 had only been on 15-minute checks previously because it was determined to be the least restrictive option. Although interviews with NA-A, RN-A, NA-B, and DON's interview identified awareness of R1's refusals to keep smoking materials at the nurse's station, non-compliance with smoking care plan, and family members bringing in smoking materials without bringing to the nurses station there was no documentation of occurrences nor documented interventions for those instances in R1's record between 12/23/25 and 2/2/26. During an interview on 2/2/26 at 12:39 p.m., the administrator stated staff were not sure where R1 obtained her smoking supplies. Since it was identified the morning of 2/2/26 by the surveyor that R1 still had a lighter and cigarettes, a nursing assistant stationed by the smoking patio would be documenting smoking supplies, lighting cigarettes for residents and storing all smoking supplies at a desk. R1 was placed on one-to-one observation with staff on 2/2/26. During an interview on 2/3/26 at 10:03 a.m., the medical director (MD)-A stated he was notified of the fire in the facility. R1 was making decisions that were difficult to help maintain safety despite the precautions that were in place. R1 was choosing to hold onto her lighter. MD-A didn't think there were any system gaps since the facility implemented a new system (yesterday) to have a staff member at the front door by the smoking patio who would keep smoking materials locked. The facility was working on designing a new smoking patio that would be away from the street. The facility policy Resident Smoking Policy last revised 11/2025, directs storage of smoking supplies is determined by the facility to individualize based on the resident's smoking assessment. Any residents who do not comply with this policy may lose smoking privileges. The resident may be subjected to discharge if unsafe practices are observed which may endanger themselves or others. The IJ was removed on 2/2/26 when it was verified the facility implemented the following corrective actions: *The facility reviewed their smoking policies with the medical director and ombudsman input. *The facility developed and implemented a comprehensive system that prevented accidents, hazards and fires related to smoking inside the facility. This (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245222	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Estates at Chateau LLC	2106 Second Avenue South Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	included a plan for residents who fail to comply with safe smoking practices. *Reassessed R1's capacity to make safe decisions regarding smoking. R1's care plan was revised with appropriate individualized interventions. *Identified like residents and their level of complying with facility policy for smoking. Individualized interventions to prevent smoking were put in place for the like residents. Residents were given safe smoking quizzes after re-education on safe smoking policies. *Educated all staff on smoking policies with a knowledge check quiz to demonstrate understanding.